STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155133	A. BUILDING _____ B. WING _____	R-C 09/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	**2100 MIDWAY ST COLUMBUS, IN 47201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Paper compliance to the recertification, state licensure and investigation of complaint IN00128441 survey completed on August 29, 2013. Review date: September 30, 2013 Facility number: 000058 Provider number: 155133 AIM number: 100283340 Surveyor: Cheryl Fielden, RN Kindred Transitional Care and Rehabilitation of Columbus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the paper compliance review to the recertification, state licensure and investigation of complaint IN00128441.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE